



Fitness and Weight Management Program Reimbursement Request

Tompkins County employees may be reimbursed for fitness facility membership, participation in structured classes such as strength training, yoga or Pilates, or a weight management program, including attendance at meetings. All classes and programs must start after employment with Tompkins County begins, and must be held at a certified facility. All weight management program reimbursements must meet the criteria of the **NIDDK** publication **Choosing a Safe and Successful Weight-loss Program** (see reverse).

Employees will be reimbursed for **pre-paid, completed, and consecutive** 6 or 12 month membership or participation in a fitness facility – up to \$100 for 6 months; \$200 for 12 months. Employees may also be reimbursed for one half the cost of a weight management program up to \$100 for a 6 month program or \$200 for a 12 month program. If participating in a fitness program, a **Physical Activity Readiness Questionnaire (PAR-Q)** or equivalent provided by the fitness facility or group fitness instructor must be completed *prior* to the start of this activity/membership. A receipt or statement of payment from the facility must be submitted with the request for reimbursement no later than 90 days after the completion of membership or classes.

I am requesting reimbursement for:	<input type="checkbox"/> Fitness Program	<input type="checkbox"/> Weight Management Program (check one)
	<input type="checkbox"/> 6 months	<input type="checkbox"/> 12 months (check one)

Section 1: Employee

Name: _____ Department: _____ Date: _____

Phone: _____ Email: _____

Section 2: Group Fitness Activity/Membership/Weight Management Program Covered By This Request

a) Name of the fitness facility, group fitness class or weight management program: _____

b) Location where fitness activity or program was provided: _____

c) Program contact person and phone number: _____

d) Dates of fitness activity/membership or weight management program covered by this request:

- From (mm/dd/yy): _____ To (mm/dd/yy): _____

REIMBURSEMENT REQUESTS MUST BE SUBMITTED WITHIN NINETY (90) DAYS OF THE COMPLETED ACTIVITY.

Section 3: Taxable or Tax Exempt Reimbursement

Whether or not your reimbursement will be considered “taxable income” depends on whether you were advised by your physician to complete the fitness or weight management program as treatment for a specific diagnosis (such as obesity, hypertension, or heart disease). **Basic membership fees for a gym, health club, or spa for general fitness or toning are always taxable, as the IRS has ruled that such fees are a “personal expense” rather than an “exempt medical expense”.** However, if you have been prescribed a weight management or fitness program by your doctor to treat a specific disease (such as obesity, hypertension, or heart disease), please have your doctor complete the section below to apply for a **tax exempt** reimbursement:

a) I hereby certify that _____ (employee name) was advised to enroll in a **Weight Management Program** and/or **Fitness Program** to treat a specific disease (such as obesity, hypertension, or heart disease).

Program Name: _____ Date: _____

Physician's Signature: _____ Phone: _____

Section 4: Please make sure you can check all of the boxes below before submitting your request.

- ☐ I have been a Tompkins County employee during the entire group fitness activity/membership/weight loss program indicated by the dates in Section 2, above.
- ☐ If requesting reimbursement for a **Weight Management Program**, I verified that the program meets the criteria of the **NIDDK** referenced above.
- ☐ If requesting reimbursement for a **Fitness Program**, I completed a Physical Activity Readiness Questionnaire (PAR-Q) or equivalent provided by the fitness facility or group fitness instructor *prior* to the start of this activity/membership.
- ☐ The fitness facility or group fitness class had an emergency plan in place to respond to medical emergencies.
- ☐ I have already paid for and completed the full 6 or 12 months of the membership covered by this request.
- ☐ I completed the program within the last 90 days.
- ☐ I have attached official proof of payment issued by the membership/program described in Section 2, above (receipt or statement; photocopies accepted).

Please complete form and send reimbursement request via fax, email, or inter-office mail to Human Resources.

For questions, please contact HR at 607-274-5528.